Patient Name_____DOB:_____

Covid-19 Vaccine Questionnaire

1. You have read the COVID-19 Emergency Use Authorization (EAU) fact sheet which was provided in your packet. ☐YES ☐NO

If no, ***STOP*PLEASE READ FACT SHEET BEFORE YOU CONTINUE.**

Do you have any of the following health conditions?

2. History of a severe allergic reaction (e.g., anaphylaxis) to any vaccine that required medical attention in the past? ☐YES ☐NO

If yes, **STOP You are not eligible to receive the COVID vaccine at this time. Please follow up with your local physician.**

3. High fever or severe illness in the past 7 days? ☐YES ☐NO

If yes, **STOP You are not eligible to receive the COVID vaccine until fever and symptoms have resolved for at least 24 hours without the use of fever reducing medication.**

4. Bleeding disorder or are on a blood thinner. ☐YES ☐NO
5. Immunocompromised or are on a medicine that affects your immune system. ☐YES ☐NO
6. Pregnant or plan to become pregnant. ☐YES ☐NO
7. Breastfeeding. ☐YES ☐NO
8. Received another COVID-19 vaccine. ☐YES ☐NO

If yes to any of the above, **STOPYou understand that the F.D.A. recommends you should discuss receiving the COVID-19 with your personal physician prior to scheduling your appointment.**

9. Have you received any other vaccinations in the past 14 days? ☐YES ☐NO

If yes, **stopYou are not eligible to receive the COVID vaccine until 14 days have passed.**

10. Have you received convalescent plasma SARS-CoV-2(COVID) in the last 90 days? ☐YES ☐NO
11. Have you received monoclonal antibody for SARS-CoV-2(COVID) in the last 90 days? ☐YES ☐NO

If yes, **STOP You are not eligible to receive the COVID vaccine until 90 days have passed.**

Acknowledgment:

The COVID-19 Moderna Vaccine include the following ingredients:

- mRNA
- Lipids (SM-102, polyethylene glycol (PEG) 2000 dimyristoyl glycerol (DMG), Cholesterol, 1,2-dostearoyl-sn-glycero-3-phosphocholine (DSPC)
- Tromethamine
- Tromethamine hydrochloride
- Acetic acid
- Sodium acetate
- Sucrose

Please mark appropriate category:

_____(1A)-Physicians, nurses, respiratory therapists, EMS, home health workers, clinical staff, lab, pharmacy, other health workers, support staff residents of long term facility, and medical support staff such as custodial staff.

_____(1B)-People 65+ and 18 years and older with a chronic medical condition such as cancer, chronic kidney disease, heart condition etc.

_____

I acknowledge that I have read the F.D.A.'s COVID-19 Emergency Use Authorization Fact sheet and have reviewed the vaccine ingredients listed above.

I agree to receive the second dose of COVID-19 vaccine in 28 days from the first dose.

I agreed to immediately report any significant adverse reaction to Patient's Health.

I agree to continue safety practices such as wearing a face mask, social distancing and frequent hand washing.

I understand that protection against COVID-19 may not be effective until at least 7 days after the second dose.

By submitting this Acknowledgment, I am requesting to receive the COVID-19 vaccine.

Name (Print): _____

Signature: _____

DOB: _____